PERCEIVED STIGMA WITHIN THE MENTAL HEALTH FIELD AS A BARRIER TO TREATMENT FOR TRANSGENDER CLIENTS

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It is only in recent years that the transgender population has received any substantial recognition within the area of psychological research. With the rising emergence of individuals identifying as transgender, the importance of continued research into the needs and experiences of this population has become apparent. The scarcity of literature in the area of clinical care for the transgender population specifically has been addressed by the journal *Professional Psychology* (Mizock & Fleming, 2011), with transgender individuals being defined as "individuals whose birth sex does not match their interior sense of gender identity or outward gender expression" (p. 208). When discussing gender issues in the present paper, the term *trans* or *transgender* will be used as an umbrella term for anyone fitting the aforementioned definition. This can include those identifying as genderqueer, gender fluid, agender, bigender, gender variant, gender non-binary, "in the middle", or Two Spirit.

Issues of clinical care are pertinent to the transgender community because this population has unique health needs. Not only is this true in the areas of medical health but also in mental health. According to the National Transgender Discrimination Survey (Grant, et al., 2011), experiencing blatant discrimination in the form of violence or harassment from health care providers is routine for those identifying as transgender. Of this sample, 19% reported being denied health care due to their transgender identity and 28% percent reported harassment in medical settings. Although these numbers primarily speak to medical health care, the role of mental health providers with the trans community does not look much better.

Psychology and the mental health field have a troubled history with issues of gender identity. Historically, gender and sexuality have been conflated into one construct and therapeutically treated as such. This created a lack of awareness for the unique issues of gender variance (Mizock & Fleming, 2011). Clinicians have held the mistaken beliefs that those with transgender identities were suffering from delusions, symptoms of schizophrenia, or simply a denial of homosexuality (Meerloo, 1976; Roback, et

al., 1976; Socarides, 1969). Anxiety and depression were seen as symptoms of these delusions rather than products of the marginalization and discrimination experienced by those of variant gender identities.

These misconceptions, along with the lack of affirmative mental health care, have caused an overall sense of distrust for clinicians on the part of the transgender community (Austin & Craig, 2015). Over the years, the experience of trans identity has been pathologized through a diagnostic category in the Diagnostic and Statistical Manual of Mental Disorders (DSM). The diagnosis was that of Gender Identity Disorder, which only perpetuated the stigmatization of the gender variant community. It was not until the DSM-5 (published in 2013) that this diagnosis was changed to Gender Dysphoria and the "disorder" label was formally dropped. The World Professional Association of Transgender Health (WPATH) advocated for this change as a step further in the direction of de-pathologizing gender identity issues. As noted by Austin and Craig (2015), the clarification was to shift the clinical focus from gender identity itself as the issue towards the discomfort of mind-body incongruence instead and affirm the transgender experience.

This shift allowed clinicians to focus on other underlying issues associated with coping with gender dysphoria. The transgender population reportedly has higher levels of anxiety and depression than the rest of the population as a whole (Budge, Adelson, & Howard, 2013). This is mostly correlated with minority stress and the unique pressures that those with a transgender identity face in today's society. Most transgender individuals are shunned from their families after coming out and therefore lack needed support that, along with financial and societal pressures, lend to additional psychological stress (Mizock & Fleming, 2011).

This rejection does not only come from their families. Trans-identifying individuals face harassment, violence, and discrimination from all levels of society. In a study by Grant et al. (2011), 44% of participants reported being denied employment due to their transgender identity. In this same study, 53% reported being verbally harassed on the street and 19% reported being denied necessary medical services. As of November 2015, the Human Rights Campaign reported that at least 21 transgender-identifying individuals, mostly transwomen of color, have been murdered in 2015 (Human Rights Campaign & The Trans People of Color Coalition, 2015).

According to the minority stress model, LGBT individuals face stigma and discrimination on a regular basis that causes mental and physical health issues associated with this stress. These stressors, and their health consequences, are dealt with across the life span (Meyer & Frost, 2013). Although the minority stress model was developed for sexual orientation, research has recently shown the effects of minority stress are associated with the transgender identity as well (Meyer, 2015). This model supports that these negative health symptoms can be buffered by good social support. Therapy and the therapeutic relationship play a role in this construct of social support. However, there are barriers between the transgender community and the mental health field due to its current clinical role regarding issues of gender and transition.

The mental health field is seen as a gatekeeper for the transgender community when it comes to the transition process. The transition process can involve any combination of hormone treatments, gender affirmation surgery, facial reconstruction, chest augmentation or reduction, and/or vocal reconstruction surgery. WPATH has established appropriate Standards of Care (SOC) for practitioners working with transgender health issues. These SOC require letters from licensed therapists in order for a person to begin hormone replacement therapy or to have any gender affirmation surgery. Past SOC used to require that a person identifying as trans attend therapy for 3 months before receiving a letter for hormone therapy and must have lived full time as their identified gender for a year before receiving a letter for gender affirmation surgery (Budge, 2015).

The most recent SOC did away with these specific requirements, and instead advocated for the benefits of receiving therapy while still requiring one letter for hormone therapy and two for gender affirmation surgery (Budge, 2015). The newest version of SOC spends more time outlining the required qualifications for a counselor to be a letter writer. Although these requirements are less stringent, they still pose problems for the trans community. Budge (2015) notes that in spite of removing the specific time stipulation of therapy, these standards still make therapy mandatory for transgender clients to be "approved" for transitioning. This means that many clients seek therapy services involuntarily. This sense of mandatory counseling breeds an attitude of negativity toward the mental health field on the part of the

trans community. Many who do not wish to seek mandatory counseling will find ways of illegally obtaining hormones. This poses many health risks because hormone use without proper direction and dosage can be dangerous. Along with this, the costs of transitional medical care can be too much for a person to afford (Grant, et al., 2011). Transgender-related health care is generally not covered by insurance, meaning it has to be paid out of pocket.

Overall, these standards have put practitioners in a place of power without providing them with proper trans-affirmative education. This has reportedly led to a rift in the therapeutic relationship based on mistrust of the mental health field (Austin & Craig, 2015). Many therapists lack a thorough understanding of the trans experience and the unique needs of the trans community. According to The National Transgender Health Survey, "widespread provider ignorance about the health needs of transgender and gender non-conforming people, deter them from seeking and receiving quality health care" (Grant et al., 2011, p. 72). With both the requirement of therapy for letter writing to seek out necessary medical services and the rates of depression, suicide, and trauma history due to minority stress, it is imperative that clinicians understand the unique needs of transgender clients and provide transgender affirming therapy.

However, in spite of the WPATH and the American Psychological Association establishing guidelines for working with the trans community, trans affirmative practice is not always the reality. There is a disconnect between transgender affirmative principles and actual practice (Austin & Craig, 2015). According to the study by Grant et al. (2011), 50% of participants reported having to educate their practitioners about transgender care. Clinicians are often unaware of the transphobia clients face on a daily basis or its effects (Mizock & Fleming, 2011). It is important that practitioners understand the scope and effects of transphobia in order to adequately meet client needs.

Unfortunately, a lack of understanding of the trans experience can result in discrimination and transphobia within the counseling room as well. It is not uncommon for practitioners to pathologize or negatively view experiences of gender variance (Austin & Craig, 2015). This can lead to denial of the gender identity of a client. The experience of this discrimination within a therapeutic setting creates

barriers to the client's treatment (Mizock & Flemming, 2011). According to a study by Avery, Hellman, and Sudderth (2001) a significantly larger percentage of their LGBT subjects (18.6%) reported dissatisfaction with their mental health services when compared to the control group, of which only 8% reported dissatisfaction. This dissatisfaction is still an issue for the transgender individuals in that demographic because the lack of knowledge and awareness of the needs of gender identity issues and their connection with mental illness leads many trans identifying people to avoid treatment altogether for fear of a hostile environment (Mizock & Lewis, 2008). For the betterment of the health of trans persons, this is a reputation the mental health field must change.

The purpose of this study is to further examine some of the roots of these hostile barriers to treatment. Specifically, this study is aimed at exploring two areas: (1) the presence of potential stigma transgender clients may experience from their counselors when seeking therapeutic services and whether these experiences are related to an unwillingness to seek treatment, and (2) the specific counselor reactions that potentially hinder these clients from seeking or returning to counseling. The history of discrimination faced by the transgender community has led to a lack of belonging and social connectedness (Austin & Craig, 2015). This has extended into the therapeutic setting. According to Austin and Craig (2015), members of the trans community need clinicians who are competent in trans issues and understand the needs of this population. A step in this direction is identifying where counselors are contributing to potential barriers to treatment. Both of these questions are aimed at focusing on the specific areas the counseling field should target for change when serving this community.

The hypothesis of this study is that there will be a significant negative correlation between perceived stigma of transgender individuals on the part of the mental health field and an unwillingness to seek treatment. That is to say those who report a high sense of stigma from the mental health field in relation to their transgender identity will also report a low willingness to seek treatment, while those who report low perceived stigma will report higher willingness to seek treatment. This research also addresses the question of whether there are specific negative counselor behaviors and reactions that are problematic for trans clients when seeking mental health services and what these behaviors are.

Methods

Participants

Participants were comprised of those self-identifying as transgender. A convenience sample was utilized, with subjects gathered via the internet. All participants were gathered from Reddit. Those who respond to the advertisement and who met the criteria were included in the study. The criteria for participating in the study were that participants had to be American citizens over the age of 18 who identify as being on the trans spectrum as defined earlier in this study and who have received or are currently receiving counseling services. The overall sample size was 199, but only 185 respondents were able to be use for the quantitative portion of the study due to incomplete responses. Of the 199 participants, 56 (28.1%) identified as transgender male, 118 (59.3%) identified as transgender females, 6 (3%) identified as genderfluid, and the remaining 19 (9.6%) identified as either bigender, in the middle, agender, genderqueer, gender non-binary, or other. The majority of the participants were Caucasian, making up 88.4% of the participant pool, 5% were biracial, and the remaining 6.6% were made up of those identifying as African-American, Asian-American, Native American, Hispanic, or other. The participants were nearly equally distributed across the regions of the country, Northeast (22.1%), Midwest (23.1%), West (26.6%), and South (28.1%). Most of the participants were between the ages of 18-24 (45.3%) and 25-34 (42.7%), while 8% were between the ages of 35-44, and the remaining 4% were 45 or older. Participants were also asked a series of questions regarding their treatment status and details about their mental health treatment history. This will be covered in further detail in the qualitative analysis portion of the study.

Procedures

This study used a survey design. Participants were recruited via the internet. A list of social media pages, web pages, and chatrooms affiliated with the transgender community was compiled and advertisements and survey links posted on appropriate web pages. Those that required administrator permission were sent a request to post a survey advertisement. Not all sources contacted responded or posted the advertisement. The advertisement explained that the study was gathering data on the stigma

experienced by transgender individuals in the mental health field. Participants were asked to take a survey and were informed that they could drop out at any point. This survey was broken into two parts, with the first measuring their willingness to seek mental health treatment, and the second measuring their experience of perceived stigma from their mental health providers.

In this study, the use of trans and transgender is defined as "individuals whose birth sex does not match their interior sense of gender identity or outward gender expression" (Mizock & Fleming, 2011, p. 208). This includes those identifying as genderqueer, gender fluid, gender non-binary, genderqueer, agender, bigender, transgender, gender variant, "in the middle", or Two Spirit. Participants were given a space to indicate their specific identification.

Those wishing to participate were directed to an online survey. They were informed beforehand that they were free to quit and opt out of the study at any point while taking it. In advertisements, the researcher addressed their understanding of the sensitivity of the topic and explained the purpose of the study. Along with this, prospective participants were informed that they would have the opportunity to answer qualitative questions describing their personal experiences and what their expressed needs might be within the counseling field. The intention behind this was to make the survey more inviting while giving the participants the feeling that they are being heard and that participating in research may benefit their future mental health care.

Measures

Demographics and transgender identity. The demographic section asked for the participant's age, race, geographic location in the country, and identified gender. Along with this information, there were questions regarding the participant's transgender identity. These questions included items such as: their stage of outness among friends, family, coworkers, and the public; if they have decided to begin the transition process; if they are taking hormones; if they live as their identified gender; if they have had a name change, etc.

Treatment and treatment seeking behavior. The next section of the survey assessed past or current treatment experience and willingness to seek mental health treatment in the future. Questions were

posed about the nature and reason for past or current treatment and its relation to transgender identity. The participants were also asked if they have ever received the diagnosis of Gender Dysphoria under the DSM-V or Gender Identity Disorder under the DSM-IV. Subjects were also questioned as to whether they have ever prematurely terminated mental health treatment and under what circumstances and if they have ever had to inform health care providers on trans care or identity issues. There were a series of items exploring the participant's willingness to engage in mental health treatment in the future. These items were on a 5-point Likert scale and were combined to produce an overall willingness score.

Qualitative. There was also a qualitative portion to this section of the survey. There were open-ended questions with space for the participants to write in their responses. These questions covered topics such as specific experiences in counseling and specific needs the subjects may have had regarding the therapeutic relationship. This portion offered the opportunity for subjects to express what they would like their therapeutic environment to look like. Only five of the open ended questions were used for analysis in this study although there were eight open ended questions in total. The five selected were chosen because they specifically addressed the personal mental health experiences of the participants, whereas the other questions ask them their opinions on various aspects of trans affirmative therapy practices, which are better suited to be used for analysis in future research. The purpose of this portion was to provide qualitative information for use in this and future research on how to best meet the unique needs of the transgender population.

Perceived stigma. The measure for perceived stigma came from the Stigma Scale developed by King, et al. (2007) for assessing perceived stigma of having a mental illness. In a study by Mizock and Mueser (2014) on coping with transphobia, this scale was adapted for use with the transgender population and called the Transgender Stigma Scale. An adapted version of the Transgender Stigma Scale used by Mizock and Mueser was used in this study. This measure consisted of 11 items as opposed to the original 28. The items were adapted to assess stigma transgender identifying individuals experienced coming from mental health providers rather than stigma experienced coming from the world at large. Items measured various aspects of perceived stigma relating to mental health providers and a transgender identity on a 5-

point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The areas of focus included disclosure (i.e., "I am scared about how my therapist will react if they find out about my transgender identity") and discrimination (i.e., "I have been discriminated against by mental health providers because of my transgender identity").

The Stigma Scale as used by King, et al. (2007) demonstrated a strong internal consistency with a Cronbach's alpha of 0.87. The adapted Transgender Stigma Scale used by Mizock and Mueser (2014) also demonstrated a strong internal consistency with a Cronbach's alpha at 0.83, discrimination being the most reliable construct on the scale at .90. Reliability testing was done on the adapted scale used in this study and after the removal of one item, the scale demonstrated strong internal consistency with a Cronbach's alpha at 0.81.

Analysis and Results

Preliminary Analyses

A preliminary analysis was run for an estimated sample size based off a confidence level of 95%. According to these calculations, an appropriate minimum sample size would have been 200. The sample for this study was 199, with 185 respondents used for the quantitative analysis.

A Cronbach's alpha was run to determine the reliability of the scale used to measure both stigma and willingness. The initial reliability test for the stigma scale yielded a Cronbach's alpha at 0.69. The internal reliability was raised to $\alpha = 0.81$ with the removal of one item ("I have not had any trouble from mental health providers because of my transgender identity"). The internal reliability of the willingness scale was $\alpha = 0.93$.

Primary Analyses

To test the hypothesis that those reporting high levels of perceived stigma would also report low willingness to seek treatment, a series of analyses were run on the two variables. The responses for both willingness and stigma were combined into one average score for each respondent representing their overall willingness score and overall stigma score. These scores were used to calculate the overall stigma and willingness means and the correlation between them. The overall mean of the data reflecting

perceived stigma was, 2.59 (SD = 0.82) while the overall mean of the data reflecting willingness to seek treatment was, 4.27 (SD = 0.97). A bivariate correlational analysis was performed for these two variables. Perceived stigma was significantly and negatively associated with willingness to seek treatment, r (185) = -.30, $p < .001$. In other words, subjects who reported greater levels of perceived stigma also reported being less willing to seek mental health treatment in the future.

In order to determine whether there are any associations between demographic variables (identified gender, age, and geographic location) and experienced stigma, a series of one-way ANOVAs were conducted. Stigma was used as the dependent variable and the demographic variables listed were used as the independent variables. Performing an ANOVA using gender identity as the independent variable resulted in a significance score of 0.4, yielding no significant differences in perceived stigma based on gender identity.. No conclusions could be drawn in terms of differences in experienced stigma regarding race because the majority of participants were Caucasian. There were also no statistically significant differences between experienced stigma based upon region of the country participants were from.

Qualitative Analyses

A qualitative portion of data was collected as well regarding the specific experiences participants had with mental health providers. The purpose of obtaining qualitative data within this study was to examine whether any specific behaviors on the part of the mental health provider emerged from the participants' responses regarding any negative experience they had in counseling. Five of the qualitative questions were analyzed and coded for themes and specific negative behaviors. These questions, asked the participant to explain (1) whether their experience in mental health services was positive, negative, or neutral and why, (2) if they have had to educate their mental health provider on transgender issues and how, (3) if they've been denied mental health services, and (4) if their experience could have been improved and how. They were also given a space to add anything extra they wanted the researcher to know about their experience.

All 199 participants' responses were used for this analysis. The participants were asked a series of close ended questions regarding their involvement in mental health services. Of the 199 participants, 97.5% reported that they had received mental health services in the past, and 60.3% reported seeking mental health services currently. 92.5% reported that they sought these services in relation to their gender identity, and 78.4% reported seeking these services as a step towards medical transition. 69.8% reported being diagnosed with either Gender Identity Disorder under the DSM-IV, or Gender Dysphoria under the DSM-V.

Data analysis strategy and coding. The data were coded by the researcher at three coding levels using the grounded theory design (Schutt, 2015). There was only one researcher who coded the data. The data were uploaded into a qualitative analysis program, NVIVO. Here the responses to the designated questions were examined and first divided into two categories: statements about positive experiences and statements about negative experiences. Although all respondents were used, not all participants answered every open ended question and not all answers were able to be coded. Only those answers that were referring to a participant's direct experience with their mental health provider were analyzed and coded. In total, 397 statements were able to be coded. Of these, 275 (69%) of the statements were negative and 122 (31%) were positive.

The statements falling into the negative experiences category were then examined again and open coded based off of counselor behavior resulting in a negative experience for the client. These were then coded into specific axial codes. This yielded eight specific codes: denied, bias, disrespectful, invalidating, misunderstanding, power differential, reductionism, and uneducated. The definitions of these codes emerged from the data. Many statements were able to be coded under multiple codes as they demonstrated the respondent experienced more than one phenomenon at a time. The majority of negative experiences fell into the category of uneducated. Because many statements were coded at more than one variable, it was not possible to use percentage to represent the number of statements covered by the codes. It was only possible to note the breadth of coverage for each code in comparison to other codes. Once these codes became saturated and no new responses yielded any additional codes, these seven codes were

divided into categories related to the mental health providers' behavior. Three categories emerged: counselor competency, therapeutic relationship dynamics, and counselor attitudes. The data was then analyzed again to verify that all of the coded statements could be coded into one of these three categories.

Counselor competency. The first category of negative counselor behavior was related to the counselor's competency to treat transgender clients. The codes falling into this category were: "denied," and "uneducated". Nineteen statements were coded under "denied," and 108 statements were coded under "uneducated". The largest amount of negative statements were coded under counselors being uneducated on topics of gender identity.

Denied. "Denied" was coded as being denied services because of their transgender identity, or being unable to find a provider who worked with transgender clients. Respondents reported being denied services due to their transgender identity and counselors' inability or unwillingness to treat transgender clients. One respondent, a Caucasian transgender female, stated, "I talked to many places (called and even went in to find out information, at least 14 places) and as soon as they found out I'm transgender they said they couldn't help me, even though I mainly go to therapy due to my bipolar, anxiety, and OCD." Many respondents reported this denial of services was a problem for them because many were seeking services as a step towards medical transition as well as out of a need for mental health support for various other issues, including anxiety, depression, and suicidal ideation. As a 34-45 year old transgender female said, "I had to go through 3 therapists that said they provided help to trans people before I actually found someone familiar with WPATH standards." This poses a major difficulty for client seeking transition because many medical providers require letters from a mental health provider through WPATH before providing transition related care (Budge, 2015).

Uneducated. The second code falling into this category was "uneducated". This was defined as the mental health provider not being educated on gender issues, the client having to educate the mental health provider on gender issues, the mental health provider having inadequate or no training in gender issues or Gender Dysphoria, they were not familiar with WPATH or transgender standards of care, or

they were unfamiliar with transition related care and the needs or cultural dynamics of working with transgender clients. This was the most salient issue in the experiences reported.

Many respondents shared that they had to educate their mental health provider on gender issues and even explain what being transgender or having Gender Dysphoria means. As a 35-44 year old transgender male stated, “It took a while to find a therapist who even knew what gender dysphoria was, much less had any experience with trans patients.” Those respondents who didn’t understand these things themselves, reported having a harder time in therapy because their mental health provider didn’t seem to know how to help them. “I have never found anyone who knows anything about trans issues and I don't know enough to really know what I am talking about so the people supposed to help me don't believe a word I am saying and I end up leaving,” reported a transgender male, age 24-35.Those who sought services only as a step to transition related medical care stated that this lack of education on the part of the mental health provider either lengthened the process of obtaining their necessary approval letters or prevented them from obtaining the care they needed in preparation for transition. For example, one transgender female stated, “I was seeing a therapist for 4~ years and she had no gender training so I couldn't start anything in my efforts to transition.” Many of the statements coded in this section were coded under multiple codes because, as this transgender woman said, “Therapists’ out of date trans info and current research, transphobic attitudes, and ignorance of non-binary information,” led to other negative behaviors impacting the clients’ experiences in treatment.

Therapeutic relationship dynamics. The second category for negative counselor behavior was related to those behaviors directly impacting the dynamics of the therapeutic relationship and rapport. The specific codes that fell into this category were: “disrespectful,” “invalidating,” “misunderstanding,” and “power differential.”

Disrespectful. The first code to emerge, “disrespectful,” was defined as the mental health provider displaying a lack of respect for the individual, for the client’s needs, for the client’s gender identity, for the sensitivity of the issues being discussed, for preferred pronouns or proper etiquette, and the client feeling subjected to the curiosity of the mental health provider. Forty-three statements were coded as

"disrespectful." Respondents reported being repeatedly misgendered by their therapists, outed without consent, and told that they needed to work on extinguishing this part of themselves. One transgender female shared, "Several therapists immediately had a negative reaction to the subject, considering it something to be reduced instead of embraced." A transgender male, between the ages of 35-44, stated, "He had seriously angered me, having outed me in front of his office staff and waiting room with a large, dramatic inquiry about my gender. After discovering I was only going to be answering questions about my mental health, not my transition, his office dropped me. I was in crisis at that time." Many other subjects reported mental health providers who were more curious about their identity and the specific details of their personal lives and transition, rather than the care of the client. Others reported experiencing a complete lack of understanding or regard for their unique needs as a transgender client. One participant, who identified as a transgender woman and reported attending a mental health rehabilitation facility, shared, "The worst discrimination I experienced was when I went to rehab this past year. They made me sleep in a male cabin because I am pre op. Because of the nature of my PTSD in particular, I did not feel safe there whatsoever. Regardless of that, I don't think it was safe at all." Many other subjects reported similar feelings of being unsafe with their mental health provider or in treatment because of the disrespect they were experiencing from their provider.

Invalidating. "Invalidating," was defined in the data as mental health professionals denying or dismissing the client's gender identity, not considering the client "trans enough," not considering the client to be an expert of their own experience, and not trusting the client to know themselves or their needs. Fifty-five statements were coded as "invalidating." Many participants reported feeling like their mental health providers behaved as if they knew more about the client's experience than the client did. Such as this transgender male, "My negative experience involved feeling like the subtle attitude and treatment shift had become 'Off' after admitting transgender feelings, and being told that the feelings may not be valid. Validation is incredibly good for someone who is transgender, because the majority of the time society is telling us that we are wrong and to ignore our gut feelings about the subject." Subjects also reported feeling as if the mental health field and medical field as a whole made it appear that clients need

the approval of a therapist to be considered “trans enough” to identify as transgender or to transition. For some, these experiences left them feeling a general sense of animosity towards the mental health field and anger and defensiveness towards their mental health providers. Several respondents shared that they felt so invalidated by their therapist that they withheld important therapeutic information from them out of fear of being unsafe or unheard. For many this feeling of being invalidated, and in turn feeling unsafe, was connected to the necessity of a therapist’s letter in order to transition.

Misunderstanding. “Misunderstanding,” was defined as the client feeling as if the mental health provider was not making an effort to understand them, their needs, or their experience, or they felt as if they were not being seen or heard by their mental health provider. Thirty-five statements were coded as “misunderstanding.” Subjects reported feeling as if their mental health providers did not understand the impact their gender identity had on the rest of their life or how they are treated by others because of their identity. Many stated that they felt their mental health providers never truly “got it,” but instead saw their gender identity as a self-doubt or a diagnosis rather than an identity they experienced. One transgender male from the West said, “I needed a therapist who didn't assume that the fundamental issue with me was a lack of masculinity, someone who would accept my gender experience as I expressed it.” Others shared that their mental health providers didn’t know how to treat them and treated them as deviant or as if they were going through a phase. They expressed that this lack of understanding kept them from trusting their mental health provider and prevented them from discussing some important therapeutic issues with them.

Power Differential. “Power Differential,” was defined as fear of the authority a mental health provider held in the relationships, the impact this authority may have on their ability to transition or receive the care they need, and the consequences of their mental health provider not understanding their experience. There were 44 statements coded as “power differential.” The majority of statements within this code pertain to the process of receiving mental health services as a means to begin transitioning. Many respondents expressed fear of their mental health provider withholding the necessary documentation to begin their transition process based off of the provider’s lack of understanding of gender issues, the client’s experience, transphobia, or other reasons.

The respondents reported feeling at the mercy of this power differential. Due to the gatekeeping position naturally held by mental health providers, respondents shared that they were put in positons where they felt their autonomy was violated as they were required to seek approval from a mental health professional before transitioning. One Midwestern transgender male said, “It's dehumanizing to have someone I don't know try to make my life choices for me.” They stated that this was a difficult phenomenon to avoid unless the counselor was aware of this power differential naturally created by the gate keeping position they held and were able to affirm and build rapport with the client. Many expressed that it was difficult to ask for or define their needs for fear of being in a vulnerable or unsafe position with a non-supportive therapist. Some subjects reported having fought with their mental health providers over what they needed from therapy and what documents they needed for transition.

Counselor attitudes. The third category of negative counselor behaviors involved the attitudes mental health providers express that negatively impact their clients. The two codes that fall into this category were “bias,” and “reductionism.” There were 49 statements coded as “bias,” and 17 statements coded as, “reductionism.”

Bias. “Bias,” was defined as a mental health provider’s attitudes of bigotry or transphobia, closemindedness, bias, judgement, intolerance, or traditional or religious views of gender. Respondents reported experiencing underlying attitudes of transphobia from mental health providers that eventually led to their therapeutic needs not being met, lying about aspects of their identity, or terminating treatment. Many stated that although they experienced negative and bigoted attitudes from their provider, they remained in therapy because they didn’t know where else to go and had already struggled to find a provider. Several subjects reported finding out that their providers had strong religious views regarding transgenderism and the provider spent a significant amount of therapy trying to “fix” the client or get the client to admit to being mentally ill for being transgender.

Reductionism. “Reductionism,” was defined as the attitude of reducing the client to their gender identity, reducing all of their issues to their gender identity, or reducing them to their diagnosis of Gender Dysphoria or Gender Identity Disorder. Respondents reported that their mental health providers would

only care to discuss or work on issues related to gender identity and had no interest in discussing other issues. Others reported that their providers treated all other issues as stemming from their gender identity. A transgender female from the South, between the ages 25-34, stated that her experience would have improved if her, “therapist realized my gender identity isn't a diagnosis, but a part of me as a person, not one of the mental health issues I am seeking treatment for.” Many felt that their providers saw them only as a diagnosis or through the lens of their gender identity and did not acknowledge other aspects of their identity or experience. Some providers treated their gender identity as a pathology or problem that needed to be overcome.

Discussion

The results were consistent with the hypothesis, indicating there is an inverse, statistically significant association between an experience of stigma and willingness to seek treatment. This implies that transgender clients are in fact experiencing stigma from their mental health providers and that this stigma is related to whether they would be willing to come back to treatment. Further research should examine this correlation more closely in an attempt to uncover whether specific types or forms of stigma are more closely related to treatment seeking behavior.

It is important to note that the overall average willingness score was closer to the higher end of the scale, indicating that most participants were willing to seek further treatment. These higher willingness scores likely contributed to the relatively modest correlation obtained. This elevated willingness score could be due to the necessity of seeking mental health treatment as a step towards transition. Further research should be performed to examine the potential moderating effects of transition requirements on willingness to seek treatment.

There were a number of specific negative behaviors on the part of mental health providers that emerged from the subjects’ responses. Counselors’ attitudes, competency, and handling of the therapeutic relationship appeared to be salient behaviors that were influential to whether the participants had positive or negative experiences with mental health treatment. This indicates that there are specific things

counselors do that have a negative impact on clients. The behaviors reported appeared to be consistent with previous literature on the therapeutic experiences of transgender clients.

A number of participants reported being denied services and being treated negatively by their mental health providers, which is consistent with the finds of Grant, et. al. (2011). Evidence can be seen in this data of the rift between therapist and patient in relation to the power differential caused by the gatekeeping model of transition requirements (Austin & Craig, 2015). Respondents reported feeling like their mental health providers don't understand their experiences or needs (Mizock & Felmming, 2011), and that in many cases this led to biased, disrespectful, and invalidating behaviors from their provider (Austin & Craig, 2015). It is also apparent that a lack of proper education in transgender issues on the part of mental health providers hinders the therapeutic relationship and prevents clients from receiving supportive services (Grant, et. al., 2011).

The most prominent issue reported was a lack of adequate training or education in gender issues on the part of mental health providers. In many ways, this extended into and influenced the behaviors in other categories, leading to disrespect and invalidation of the client. It also had a major impact on the quality of care in that these patients were not getting the services and support they needed to come to achieve greater awareness and stability of self along with transition related needs. When it is required that persons obtain a letter of support and proof of diagnosis from a mental health provider before receiving necessary medical care, and mental health providers are unaware of the needs of this population or the standards of care, this poses a major problem. This research sheds light on the pertinence of establishing and providing adequate training for future and current therapists on cultural competency regarding issues of gender and gender identity.

Further research should be performed on these specific experiences of transgender clients to examine the salience and prevalence of these negative counselor behaviors and the impact on the clients and therapeutic relationship. It is possible that these specific counselor behaviors contribute to the relationship between stigma and willingness to trust and act as mediators between the two. Further research should explore this. Respondents expressed many thoughts and feelings towards the gatekeeping

role of the mental health field, and indicated that it affected and motivated their therapeutic experiences. It would be beneficial to conduct research on the effectiveness of the gatekeeping model and the feelings and attitudes of the transgender community towards how it is handled and how it impacts them.

Limitations

Although the results were statistically significant, this research could have benefitted from a larger and more diverse sample size. This population proved hard to study due to the difficulty of accessing willing participants. Along with this, there was not an adequate variation in gender identity or race. The majority of participants were Caucasian transgender women. This lowers the generalizability of the research when applying it to the transgender population as a whole, particularly because it almost entirely excludes the experiences of trans people of color, who tend to experience more discrimination than their Caucasian counterparts (Grant, et. al., 2011). Another limitation in the area of sample size is that the sample was entirely pulled from one source. Although multiple internet communities were contacted, respondents only came from Reddit. It is unknown whether the experiences of the trans community on Reddit are representative of the experiences of the trans community as a whole. Looking at the imbalance among participant demographics, it can be assumed that this study was subject to sampling bias.

There were also some limitations in the survey design. Multiple respondents could not be used in the overall analysis due to incomplete responses in the stigma survey. This is due to the fact that the questions on the stigma survey were optional. Gender identity was also difficult to assess because the participants had the option of selecting multiple identities and the researcher had to determine which identity appeared to be most salient for the participant.

Researcher bias is a limitation for the qualitative portion of this study. Although the researcher continuously assessed for bias and attempted to remain objective, it is inevitable that some amount of researcher bias influenced the analysis of data and the resulting themes. This could be alleviated in the future by having a second researcher analyze and code the data for consistency.

Conclusion

Overall, this research served to provide a stable groundwork for further research into the experiences and needs of the transgender community within the mental health field. There is an apparent problem with how the mental health field has handled transgender clients, evidenced by their reports of experiencing stigma and negatively impactful treatment from mental health providers. This problem becomes more salient when this treatment is shown to be related to an unwillingness of these clients to seek further help.

With the growing number of transgender individuals coming out and working to find their place in this world, it is imperative that mental health providers know how to serve the needs of this population. The stigma experienced by the transgender population should cease to extend into the counseling room. As transgender medical and mental health care evolve, there will be a continued need for better and more responsible understanding of the cultural dynamics of the trans community. Listening to the voices of this community is the first place to start.

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